

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 12337
Registrar's No. 2653

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Perry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (In this place) 1 month		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 0790	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital				d. STREET ADDRESS (If rural, give location) Route #1	
3. NAME OF DECEASED (Type or Print)		a. (First) JOHN		b. (Middle) HENRY	
		c. (Last) SMITH		4. DATE OF DEATH Month Day Year MARCH 10, 1953	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH Apr 6, 1882	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm		9. AGE (In years last birthday) 70	
11. BIRTHPLACE (City and State or Foreign Country) Perry County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Issac Smith		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Arnold Smith, Crystal City, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral Arteriosclerosis</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>diffuse</i> DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 334X	
22. I hereby certify that I attended the deceased from 2-10-53, 19__, to 3-10-53, 19__, that I last saw the deceased alive on 3-10-53, 19__, and that death occurred at 3:07A m., from the causes and on the date stated above.					
23a. SIGNATURE <i>John W. Wilson M.D.</i>		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 3-10-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 3-10-53		24c. NAME OF CEMETERY OR CREMATORY Crystal City, Mo.	
24d. LOCATION (City, town, or county) (State) Crystal City, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Politte F.H., Crystal City, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Ronald C. Yahnke

Licensed Embalmer No. *3617*

P. O. Address *Thurston*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.